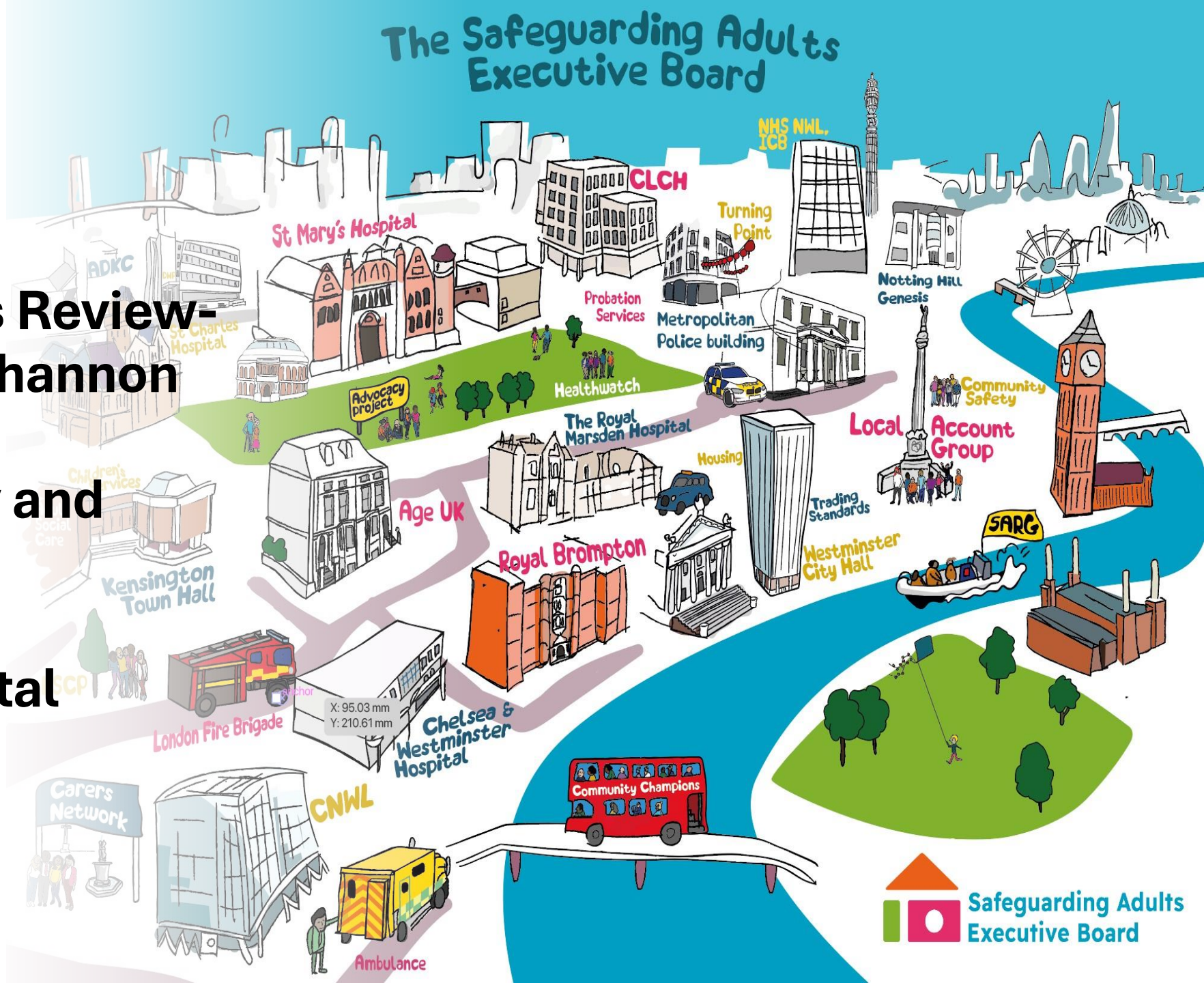
Safeguarding Adults Review- Professor Richard Shannon

Executive Summary and Learning Briefing

Multi-Agency Hospital Discharge Audit



Background and Learning from Safeguarding Adults Review

This **executive summary** provides an overview of the work undertaken as part of a Safeguarding Adults Review (SAR) commissioned by the Safeguarding Adults Executive Board (SAEB) of Kensington and Chelsea and Westminster.

The review examined the circumstances in which Professor Richard Shannon passed away in hospital as a consequence of sepsis related to a Category 4 pressure ulcer which developed between his initial discharge from hospital and readmission only eight days later.

Professor Shannon's death was referred to the coroner's court, and a Prevention of Future Death's (PFD) report was issued which identified a number of concerns in relation to how agencies worked together.

The SAEB made a recommendation to complete a SAR, on a discretionary basis, to seek assurance that the multi-agency response to the PFD report had resulted in changes to the hospital discharge process and to evidence this via a multi-agency audit. This audit was completed by an independent reviewer, Mick Haggar.

Sharing learning is a key priority of the SAEB and ensures that lessons in relation to safeguarding adults supports direct practice and encourages a culture of continuous improvement.

All staff and managers are encouraged to read this briefing and reflect together with your team(s) on how the issues presented resonate with your own practice and consider how you can embed the learning.

Making Safeguarding Personal - Involving family and friends in our reviews

As part of the discretionary Safeguarding Adult Review, the SAEB had contact with Professor Shannon's family and friends for their views and support in developing a pen picture summarising who Professor Shannon was, what was important in his life and his achievements.

It is with their permission that Professor Shannon's real name is used, as per the process also used as part of the coroner's inquest in which the PFD report is in the public domain.

The SAEB would like to thank Professor Shannon's family and friends for their valuable contributions. Some excerpts from the pen picture, which is included in the full audit report are included in this executive summary.

Professor Richard Shannon – a pen picture

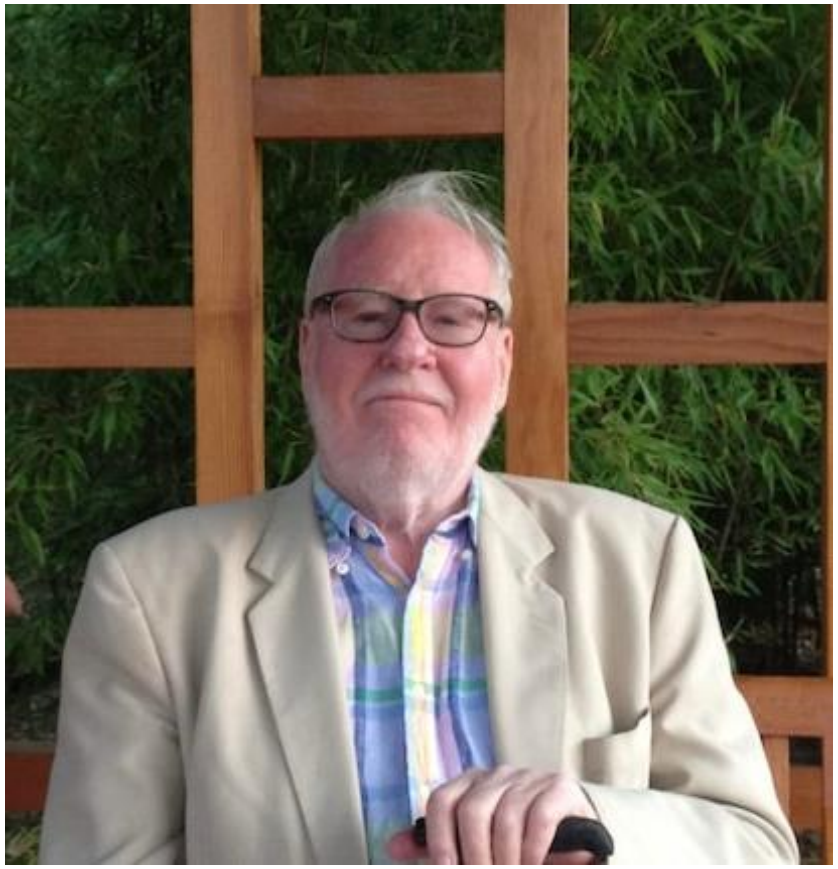
Dick, as he was known by his friends, had charismatic charm. He loved the arts, politics, music and entertaining.

He was an exceptional scholar, acquired his first degree at the University of Auckland, New Zealand and obtained a scholarship to come to Cambridge where he completed his PhD. He went onto teach modern history at Auckland and then at the University of East Anglia.

He had profound academic knowledge and people loved to both converse with him and listen to him. Dick was a complete twinkle in the eye of everyone who knew him and was bolder than life**.** His friends also describe him as a wise man who was very good at giving advice. Many of his students would stay in touch even after 20-30 years had passed, which demonstrated just how fond people became of him.

The Telegraph published an article which stated; ***"His warmth, informality and cultural breadth enlivened an insular department. He was a popular and genial head, and later dean of faculty, smoothing tensions with humour."***

One of Professor Shannon's friends reflected that; ***"He was quite a character, a dear friend of moral excellence and personal integrity … who left behind a great legacy".***



What do hospital discharge pathways look like in the Bi-Borough

Hospital Trusts across North-West London use a range of discharge options, including informal support from voluntary organisations, support from NHS community teams, provision of packages of care and reablement services from Adult Social Care (ASC), residential placements, and NHS Continuing Healthcare.

The current hospital discharge pathways in place for residents of the Bi-Borough of Kensington and Chelsea and Westminster operate as a mixed model whereby a Pathway 1 ‘discharge to assess’ approach is in place in Chelsea and Westminster and St Mary’s Hospitals, but not for out of borough hospitals where Bi-Borough residents may be admitted.

Pathway 1 Model – Discharge to Assess

The Pathway 1 ‘discharge to assess’ model is an integrated approach to early recognition and safe facilitation to discharge patients who are medically fit (also referred to as medically optimized) to their own homes where further assessments of their health and social care needs can be completed. Based on the recommendations from the needs-based assessment completed by the multi-disciplinary team in the hospital, an integrated team of home carers and therapists provide immediate care upon discharge. A social care assessment of the person’s further rehabilitation potential and long-term care needs then takes place within the first few days of the patient returning home.

A different model of discharge operates in the out of borough hospitals, in which the assessment of needs takes place in the hospital and a referral is then made to ASC and/or community health to set up services in the community, and these hospitals cannot directly access the services that are part of the Pathway 1 model.

Hospital Discharge Audit - Aims and Scope

The purpose of the audit was to assess the effectiveness of the hospital discharge models in place comparing the Pathway 1 approach with the pathways in place in out of borough hospitals. The cases audited were from St. Mary's, Chelsea & Westminster and University College London Hospitals.

The audit also evaluated how well agencies worked together with regards to:

- The quality of health and social care assessments.
- The effectiveness of information-sharing and communication.
- The timeliness and safety of hospital discharges.
- The consideration of reablement resources and home care hours.
- The involvement of patients and their families.

Two audit tools were used to meet these objectives:

Part A – patient's experience in hospital

- Completion by Independent Consultant – Mick Haggar
- Evaluate interventions in hospital and how discharge process worked
- Review of social care and health records

Part B – patient's experience post-discharge

- Completion by agencies involved following the patient's discharge, including community health, ASC reablement services and home care providers.
- Feedback on co-ordination of care and support services in the community

Key findings and learning points

Information sharing, communication and coordination between services involved in hospital discharge was found to be good across all hospital sites but was more effective overall where the Pathway 1 model was used

The current model of setting up ‘Bridging Care’ home care services as part of the Pathway 1 model to support timely discharges home involves using both ‘in-house’ agencies as well as ‘spot-purchase’ support. This can create confusion and complexity in care arrangements

Information sharing from hospital to community health services was found to be variable, which can lead to delays in adults being seen by community health services and relevant professionals not always receiving information about the hospital admission

Mental capacity assessments were not done in all cases where decision-making in relation to the hospital discharge or related decisions were in doubt and a formal assessment was indicated

Ward-based discussions with family and friends well-documented in health-based recording systems but were not consistently shared with ASC or Community Health

What we are doing to respond to the learning

The SAEB acknowledges that the follow up actions to respond to these questions are primarily being addressed through the North-West London Integrated Care Board (ICB) via the Discharge Executive Group (DEG) as well as more local work being led by the Hospital Social Work Service in the Bi-Borough. These workstreams do not sit within the realm of adult safeguarding but are part of business-as-usual work within the partnership.

The SAEB and its partner agencies will share the learning from this audit with the North-West London System Quality Group as well as the London Discharge Group.

Key areas of work being taken forward:

- The Hospital Social Work Service in the Bi-Borough is strengthening arrangements for working with our main out of borough hospitals to ensure that residents can access Pathway 1 in a similar manner as if they were admitted to the hospitals located in the Bi-Borough.
- The Hospital Social Work teams will continue to promote awareness of the range of discharge options via Pathway 1 across all relevant wards and will utilise professionals working in the Pathway 1 multi-disciplinary team to strengthen assessments which consider whether a patient is suitable for reablement services. This will also be reinforced in ward accredited induction programmes.
- Central London Community Healthcare (CLCH) are undertaking current work to ensure there is greater clarify around the core offers for community health services, and the collaborative working across CLCH and acute trusts to ensure robust and joined up communication.
- CLCH will continue to provide a dedicated telephone advice line in which UCLH staff can contact District Nurses for case discussions.
- The SAEB is supporting acute trusts in the Bi-Borough to review and update mental capacity assessment templates to ensure greater consistency of practice.

Further resources and reading

The SAR audit report is published on the SAEB website, along with this executive summary / learning briefing.

The SAEB website has a range of professionals' resources and learning briefings on a range of safeguarding topics, as well as recordings of our Lunch and Learn webinars.

Other useful links:

Hospital Discharge and Community Support Guidance – GOV.UK
Being Discharged from Hospital – NHS
NHS England » Improving hospital discharge resources
Good Practice Guide for Hospital Discharges – Carers Trust
Mental Capacity Act Code of Practice

Concerned about abuse or neglect?

To raise a safeguarding adults concern, contact the Information and Advice Teams:

Westminster: 020 7641 2176 adultsocialcare@westminster.gov.uk

Kensington & Chelsea: 020 7361 3013 socialservices@rbkc.gov.uk

For more information on this briefing contact:

Makingsafeguardingpersonal@rbkc.gov.uk

www.saeb.org.uk

Safeguarding Adults Executive Board